

The Extraordinary Life Workshop:
Using Energy to Optimize Your Life

CONFIDENTIAL PARTICIPANT PROFILE

Please print and use blue or black ink.

Please return completed forms to: Melanie@MelanieRoche.com

First Name

Last Name

Address

City

State

ZIP

Country

Daytime phone*

Evening phone*

If international, please include country/city codes.

Occupation

List medications currently being taken or taken within the last 2 years. Please list conditions for which they are/were being taken:

List present physical problems:

Have you ever been hospitalized and/or treated for psychological difficulties as an inpatient, or has hospitalization or inpatient psychological treatment been recommended?

_____ Yes

_____ No

If yes, for what and when? List date(s).

Please answer all questions. Mark "N/A" if not applicable. Submit original and make a copy for your records.

The Extraordinary Life Workshop: Using Energy to Optimize Your Life

INFORMED CONSENT AND RELEASE

I have registered for The Extraordinary Life Workshop: Using Energy to Optimize Your Life, which includes workshops, classes, and other related activities (herein after collectively called the Program) offered by Melanie Roche and Roche Healing Arts.

I have been informed that the general nature of the Program, and the techniques used therein, are designed to provide a general overview of The Extraordinary Life Method and will present situations that may be physically or emotionally stressful at various stages of the Program.

I have been informed that the Program is designed for healthy and emotionally stable people and that a person who, as a result of a physical, mental or emotional disorder, is unable or unwilling to explore emotionally stressful situations or unable to deal with other aspects of the Program, should not enroll in the Program.

I represent to you that I am not now, nor have I been hospitalized for a mental disorder within the past five years. I am not currently taking psychotropic medications (which include anti-anxiety agents, anti-manic agents, anti-depressants, psychostimulants, anti-panic medications, and anti-psychotics), seizure disorders medications prescription sedatives and have not taken psychotropic medications, seizure disorder medications or prescription sedatives within the following proscribed periods, and no such treatment has been recommended. In the case of psychotropics classified as anti-psychotic, the proscribed period shall be two years. In the case of other psychotropics, seizure disorder medications or prescription sedatives, the proscribed period shall be six months. I understand that this prohibition shall apply to psychotropic medications, seizure disorder medications or prescription sedatives prescribed to treat a mental or emotional disorder. I further represent that I am physically and mentally healthy, that I have no knowledge or reason to believe that I am emotionally unstable, and that I will consult my own physician or other health professional if there is any question in my mind about my physical or emotional ability to participate in the Program. I agree to notify Melanie Roche and other workshop leader(s) should my condition change prior to the commencement of the Program, and I understand that any such changes may require that I cancel my participation in the Program and that my withdrawal will be subject to the terms of the Cancellation Policy.

If at any time I feel that I am unwilling or unable to engage in any exercise or aspect of the Program, or if I experience any unwanted symptoms or unusual discomfort or stress, I agree to inform the person(s) leading the Program at once.

I understand that the Program is an introductory program and does not prepare a participant to practice the science of healing, which requires substantial further training and certification.

I understand and agree that all written and other materials which may be presented during the Program are the property of Melanie Roche and Roche Healing Arts. I understand and agree that videotaping, audiotaping, and photographing of all or any portion of the Program is strictly prohibited. I agree not to reproduce, copy, or otherwise duplicate, publish or disseminate in any way, any such materials without the express written permission of Roche Healing Arts/Melanie Roche or the Workshop Leader(s).

I, on my own behalf and on behalf of my past, present and future agents, representatives, attorneys, heirs and assigns, for good and valuable consideration received from or on behalf of Melanie Roche, her past, present and future agents, representatives, heirs and assigns and Roche Healing Arts, and its respective past, present, and future affiliates and its respective agents, employees, subcontractors, contractors, representatives, officers, directors, assigns, successors and predecessors in interest (the "Released Parties"), hereby remise, release, acquit, satisfy, and forever discharge the Released Parties, of and from all, and all manner of, action and actions, cause and causes of action, suits, debts, dues, sums of money, liens, accounts, reckonings, covenants, contracts, controversies, agreements, promises, damages, judgments, executions, medical/hospital expenses, loss of earnings and earning potential, pain and suffering, claims and demands whatsoever, in law or in equity, arising or relating to my participation in the Joy of Presence: The Extraordinary Life Method program, which Released Party ever had, now has, or which may arise against the Released Parties.

I understand that any alteration of this Informed Consent and Release automatically cancels my admission into this program. I have not altered the terms of this Informed Consent and Release.

Participant Signature

Date

Name (Please Print)

Age of Participant

Parent or Guardian Signature (if participant is under 21)

Relationship to Participant

Submit original and make a copy for your records.